What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

Vol. 2, No. 22, June 2002 Navrongo Health Research Centre

WHERE DO WE GO FROM HERE?

Introduction

The Ministry of Health, the Ghana Health Service, and the ultimate beneficiaries of excellent, accessible, and affordable health care now know what works and what fails in reorienting health service delivery at the periphery. The Navrongo Community Health and Family Planning Project has proved that retraining and redeploying community health nurses to live and provide doorstep services in rural settings widens access, reduces cost, and improves health care delivery. Thus the desire of the Government of Ghana to achieve the long-term goal of growth and development for its people is being met. This desire is captured in the vision 2020 document which has identified five main areas for priority attention in the medium to long term. Among them is maximizing the healthy and productive lives of people. The Medium Term Health Strategy (MTHS) towards vision 2020 sets the direction and provides a framework for guiding reform and development in the health sector. It describes how the health sector can contribute to the improvement of the health of the people. Notably among them is strengthening the human resource planning, management, and training as a means of providing and retaining adequate numbers of expert and well-motivated health teams to provide services (MTHS 1999).

Infants look up to policymakers to make the right decisions about bringing down mortality figures

Two major problems associated with human resource development have been the overextension of already inadequate numbers of staff as well as uncoordinated training not related to priority needs. Addressing these problems calls for guidelines that would give priority to peripheral human resource training and distribution, with an appropriate mix to provide services. The objectives of the MTHS are to provide universal access to primary health services and improve quality as well as foster linkages with other sectors. Strategies outlined in the MTHS document aimed at achieving the above objectives include reprioritization of health services, expanding existing facilities, evaluating the possibility of starting new training institutions, and changing the nature of training to reflect the needs of the new health service.

Despite tremendous improvements in the health status of the ordinary Ghanaian over the years health for all is only now in sight. The state of the Nation's report (2000) indicated there are still significant variations between regions and between the urban and rural areas. For example, while the national average of infant mortality is 66/1000 live births, that of the Upper East Region (UER) is 105/1000 live births. This figure is even higher in the districts. The IMR for the Kassena-Nankana District was 124/1000 in 1995 (Binka et al. 1999) and the MMR is currently estimated at 600/10000 (Ngom et al. 1999). Under-five mortality in 2000 was 153/1000 falling to 116/1000 in 2001 as against the national average of 110/1000 and 95/1000 respectively according to the Ghana Living Standard Survey 4 (GLSS4). The second Five Year Programme of Work (5YPOW — 2002-2006) with the theme "Partnership for Health — Bridging the Inequalities Gap" seeks to do more to address these problems.

The Ghana Poverty Reduction Strategy (GPRS) has also identified deeper inequities in access to quality health services in the four most deprived regions of Ghana. The UER remains the most deprived among the four with poverty levels well above the national average. Among the many objectives of GPRS is the goal to increase access to quality health services.

The ruling New Patriotic Party Government's manifesto on public health states that government will ensure that at least a Community Health Nurse (CHN) is located in every hamlet of the country. It goes further to indicate that more CHN shall be trained to carry out the campaign against malaria, typhoid, and STDs including HIV/AIDS (p. 31). All these objectives can only be achieved when schools are set up to train more nurses to take up responsibilities.

The national picture and the Community-based Health Planning Services (CHPS) Initiative: At Ada-foa in August 1999, the directors of the Ministry of Health gathered to discuss the logistical implications of scaling up the project. In the course of this meeting, the Director of Human Resources, Dr. Ken Sagoe, noted, among other things that one of the major challenges that scaling up will face is acquiring the numbers of community health nurses required by districts to implement the programme.

Staff refusing postings: At present, national nurse training facilities seek applicants from a national pool of eligible women. Eligibility is defined by schooling level-SSCE or GCE graduates with credits or passes in English, Mathematics and Science. Trained nurses are assigned to a regional staff pool and are posted and distributed from the Regional Health Administration. This design of the programme is associated with problems that further constrain the availability of nurses. Individuals posted to a community are often from another ethnolinguistic group. Language difficiencies diminish work effectiveness and morale. Lack of social amenities, good schools for their children, opportunity for career progression, and family commitments compound the problem. Moreover, the procedure that is used does not adequately involve communities in the selection and posting of nurses. As outsiders posted to the communities, Community Health Officers (CHO) require extensive system support to enable them to build community knowledge, trust, and participation in the health programme. The use of outsiders also elevates the requirements of residential quarters, since nurses assigned to communities are far from their homes and families. Use of local, trusted, and well-trained nurses would obviate the need for the payment of village hardship allowances and other measures that make community residence palatable to the CHO involved in the programme.

The problem of numbers: The UER is characterized by dispersed settlements, seasonal flooding, and inadequate roads, making it hard for health workers to reach various communities. It is listed as one of the most deprived regions in Ghana and experiences a growing shortage of health staff. There are five CHN training schools in the country with an average intake of fifty students each per year. As a consequence, no more than ten CHN are posted to the region annually, and for the past five years the number of CHN providing services in the region declined from 200 to 97 because attrition far outpaces the arrival of new nurses. With the current level of service coverage, the region presently has a staff shortfall of 40 percent, a dilemma that will grow unless action is taken to address the problem. The population of UER is 917,251 (2000 census) living in 475 communities giving an average of 1 CHN per 9897 people and 1 per 5 communities. These numbers are woefully inadequate if the inequalities in health are to be bridged.

The way forward is to find an inexpensive and sustainable way to train more nurses for doorstep health care

It is clear to all planners that individuals seeking positions as community health nurses are not in short supply; rather, the causes of the low numbers of nurses in the districts are threefold: attrition of trained nurses to higher grades as staff registered nurses within the Ghana Health Service; attrition outside the health profession due to burnout or other personal reasons related to marriage and family, other economic opportunities and, lateral movement into health NGOs and private sector roles.

The acute shortage of community health nurses across the country is exacerbated by the fact that the capacity to train replacement nurses is very low. At present, the annual output of nurses is barely sufficient to sustain current numbers and is far below the extra 2000 additional nurses that are required for the CHPS programme.

In the Ada-foa meeting, discussion of possible solutions to the problem of the shortage of Community Health Nurses focused on the need for every region to have a training school for community health nurses. Lack of resources stifled this initiative from the periphery. But the issue cannot be shelved anymore and the way forward is to find cost effective and sustainable means of providing the required numbers of nurses for the CHPS programme.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant from the Vanderbilt Family to the Population Council.